100.1 The amounts disbursed to each nursing facility will be based on audited costs for fiscal years ending in 1997. The lesser of the Audited Actual Direct Care Cost per Day (per Cost Report, Schedule B, including any savings) and the Audited Actual Direct Care Cost per Day (per Cost Report, Schedule G, line 1) is multiplied by the audited State days. The resultant dollar value is a specific percentage of the total amount for all nursing facilities. This specific percentage is multiplied by the total State and Federal allocation to determine the amount that each nursing facility will receive.

Example: Nursing Home "AA"	
1. Schedule B	
Audited Actual Direct Care Cost per Day	$47.00
2. Schedule G, Line 1	
Audited Actual Direct Care Cost per Day	$45.00
3. Audited State Days	12000
4. Dollar Value (equals $45.00 X 12000 days)	$540,000
5. Total of #4 for all Nursing Facilities	$50,000,000
6. Percentage that Nursing Home "AA" will receive of the State and Federal amounts (Line 4/Line 5)	.01

Effective 7/1/99

100.2 Schedule SP of the nursing facility cost report will be used to determine the actual amounts paid to non-administrative staff. Schedule SP will include the audited costs of all non-administrative staff, including benefits, for the fiscal year ending in 1997. These amounts will be inflated to the fiscal years ending in 1999 and 2000. The inflated audited costs of all non-administrative staff for the fiscal year ending in 1997 will be compared to the inflated audited costs, including benefits, for both the fiscal year ending in 1999 and 2000. The total amounts paid for non-administrative staff for the fiscal years ending in 1999 and/or 2000 in excess of the total amounts paid for non-administrative staff for the fiscal year ending in 1997 inflated, will be applied against the supplemental payment. Any amounts of the supplemental payment not expended by the nursing facility in the fiscal year ending in 1999 and/or 2000 will be recouped at time of audit settlement for the fiscal year ending in 2000.

120 EXTRAORDINARY CIRCUMSTANCE ALLOWANCE

Facilities which experience unforeseen and uncontrollable events during a year which result in unforeseen or uncontrollable increases in expenses may request an adjustment to a prospective rate in the form of an extraordinary circumstance allowance. Extraordinary circumstances include, but are not limited to:

* events of a catastrophic nature (fire, flood, etc.)
* unforeseen increase in minimum wage , Social Security, or employee retirement contribution expenses in lieu of social security expenses
* changes in the number of licensed beds
* changes in licensure or accreditation requirements

If the Department concludes that an extraordinary circumstance existed, an adjustment will be made by the Department in the form of a supplemental allowance.

The Department will determine from the nature of the extraordinary circumstance whether it would have a continuing impact and therefore whether the allowance should be included in the computation of the base rate for the succeeding year.

121 Certificate of Need Extraordinary Circumstance Allowance

121.1 Based on findings made by the Commissioner of the Department of Human Services (hereinafter, the Commissioner), the Department may approve extraordinary indirect, routine, and fixed costs in excess of the provider's approved Certificate of Need (CON) that are within the upper limits established by the Department for the indirect and routine components, when all of the following conditions are met:

121.1(a) Costs would ordinarily be allowable under Federal Regulations and these Principles of Reimbursement;

121.1(b) Costs would have been allowable under the CON had a CON amendment been filed within the time constraints as outlined in the CON statutes and approved by the Department;

121.1(c) Approval is necessary in order for the Provider to obtain favorable refinancing, as determined by the Department;

121.1(d) Failure to approve may adversely affect patient care; and

121.1(e) In the Department's judgment, approval will further the Department's goal of ensuring that public funds are only expended for services that are necessary for the well being of the citizens of Maine.

121.2 Department approved costs, as determined in Section 121.2, from the CON will be recognized at the time the Department approves the Certificate of Need Extraordinary Circumstance Allowance for a nursing facility.

121.3 The Department may require that the Provider(s) or owner of the Provider(s) who have been granted a Certificate of Need Extraordinary Circumstance Allowance under these Principles, be subject to the following conditions:

121.3(a) Be managed through an unrelated management company;

121.3(b) Hire a licensed administrator, through an unrelated management company, who is approved by the DHS Division of Licensing and Certification; and

Sections 121.3(a) and 121.3(b) will be in effect for a period of time determined by the Department.

121.4 If the provider fails to obtain the acceptable refinancing described in Section 121 within 15 months of the date the Commissioner made the findings under Section 121.1, the Department may 1) recapture costs approved under Section 121 at time of audit; or 2) withdraw the Extraordinary Circumstance Allowance under Section 121.

130 ADJUSTMENTS

130.1 Adjustment for Unrestricted Grants or Gifts. Unrestricted Federal or State grants or gifts received by a facility and which have been deducted from operating costs for purposes of reimbursement will be added back to the direct patient care, indirect patient care and routine cost component for purposes of calculating a base rate.

130.2 Adjustment for Appeal Decisions. The Department will adjust any interim or final prospective rate to reflect appeal decisions made subsequent to the establishment of those rates.

130.3 Adjustments for Capital Costs. The Department will adjust the fixed cost component of an interim or final prospective rate to reflect increases or decreases in capital costs. For example costs which have been approved under the Maine Certificate of Need Act or refinancing.

140 APPEAL PROCEDURES - START UP COSTS - DEFICIENCY RATE - RATE LIMITATION

140.1 Appeal Procedures

140.1.1 A facility may administratively appeal any of the following types of Division of Audit determinations:

1. Audit Adjustment
2. Calculation of final prospective rate
3. Adjustment of final prospective rate or a refusal to make such an adjustment pursuant to these Principles.

140.1.2 An administrative appeal will proceed in the following manner:

1. Within 30 days of receipt of an audit or other appealable determination, the facility must request, in writing, an informal review before the Director of the Division of Audit or his/her designee. The facility must forward, with the request, any and all specific information it has relative to the issues in dispute, note the monetary amount each issue represents and identify the appropriate principle supporting the request. Only issues presented in this manner and timeframe will be considered at an informal review or at a subsequent administrative hearing.

2. The Director or his/her designee shall notify the facility in writing of the decision made as a result of the informal review. If the facility disagrees with the results of the informal review, the facility may request an administrative hearing before the Commissioner or a presiding officer designated by the Commissioner. Only issues presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within 30 days of receipt of the decision made as a result of the informal review.

3. To the extent the Department rules in favor of the facility, the audit report or prospective rate will be corrected.

4. To the extent the Department upholds the original determination of the Division of Audit, review of the results of the administrative hearing is available in conformity with the Administrative Procedures Act, 5 M.R.S.A. §11001 et seq.

150 START UP COSTS APPLICABILITY

Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient is admitted for treatment, or where the start-up costs apply only to nonrevenue-producing patient care functions or nonallowable functions, to the time the areas are used for their intended purposes. Start-up costs are charged to operations. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility will be accumulated in a single deferred charge account and will be amortized when the first patient is admitted for treatment. If a provider intends to prepare portions of its facility on a piecemeal basis (e.g., preparation of a floor or wing of a provider's facility is delayed), start-up costs would be capitalized and amortized separately for the portion(s) of the provider's facility prepared during different time periods. Moreover, if a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas.

Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the Department need not be capitalized, but rather will be charges to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the Department, these costs need not be capitalized, but will be charged to operations in the periods incurred.

For program reimbursement purposes, costs of the provider's facility and building equipment should be depreciated over the lives of these assets starting with the month the first patient is admitted for treatment, subject to the provider's method of determining depreciation in the year of acquisition or construction. Where portions of the provider's facility are prepared for patient care services after the initial start-up period, these asset costs applicable to each portion should be depreciated over the remaining lives of the applicable assets. If the portion of the facility is a patient care area, depreciation should start with the month the first patient is admitted for treatment. If the portion of the facility is a nonrevenue - producing patient care area or nonallowable area, depreciation should begin when the area is opened for its intended purpose. Costs of major

movable equipment, however, should be depreciated over the useful life or each item starting with the month the item is placed into operation.

151 COST TREATMENT FOR REIMBURSEMENT

151.1 Where a provider prepares all portions of its facility for patient care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratable over a period of 60 consecutive months beginning with the month in which the first patient is admitted for treatment.

151.2 Where a provider prorates portions of its facility for patient care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for patient care services during different periods of time.

152 DEFICIENCY PER DIEM RATE.

When a facility is found not to have provided the quality of service or level of care required, reimbursement will be made on 90% of the provider's per diem rate, unless otherwise specified. This "deficiency rate" will be applied following written notification to the facility of the effective date of the reduced rate for any of the following service deficiencies:

152.1 Staffing over a period of two weeks or more does not meet the Federal Certification and State Licensing requirements, except where there is written documentation of a good faith effort to employ licensed nurses to meet the licensed nurse requirements over and above the full time director of nursing;

152.2 Food service does not meet the Federal Certification and State Licensing requirements;

152.3 Specific, documented evidence that the care provided does not meet the Federal Certification and State Licensing requirements. Such penalty to be effective no sooner than 30 days from written notification that such deficiencies exist;

152.4 Failure to correct, within the time frames of an accepted Plan of Correction, deficiencies in meeting the Federal Certification and State Licensing requirements, which cause a threat to the health and safety of residents in a facility or the surrounding community;

152.5 Failure to submit a cost report, financial statements, and other schedules as requested by the Division of Audit and to maintain auditable records as required by these Principles and other relevant regulations may result in application of the deficiencies per diem rate. The deficiency per diem rate for these items will go into effect immediately upon receipt of written notification from the Department of Human Services.

152.6 Failure to correct MDS as requested in writing and submit within the specified time outlined in Section 41.21 of these Principles of Reimbursement.

A reduction in rate because of deficiencies shall remain in effect until the deficiencies have been corrected, as verified by representatives of the Department of Human Services, following written notification by the provider that the deficiencies no longer exist. No retroactive adjustments to the full rate shall be made for the period that the deficiency rate is in effect unless the provider demonstrates to the satisfaction of the Department that there was no just cause for the reduction in payment.

160 INTENSIVE REHABILITATION NF SERVICES FOR TRAUMATIC BRAIN INJURED INDIVIDUALS (TBI)

It has been determined that the reasonable cost of comprehensive rehabilitative services of traumatic brain injury is an allowable cost. This requires that the facility possess characteristics, both in terms of staffing and physical design, which create a unique unit providing comprehensive rehabilitative TBI services.
The Department will require that the facility obtain prior approval of its staffing pattern for the nursing and clinical staff associated with the TBI unit from the Bureau of Medical Services. In the event a facility believes that the needs of the residents it serves have increased or decreased, the facility must request prior approval from the Bureau of Medical Services authorizing such a change to its staffing pattern.
The Department will recognize a NF-TBI unit when it is a distinct part of a dual-licensed nursing facility. The facility will be reimbursed for the average annual per diem cost for TBI rehabilitative services provided to those individuals classified in need of intensive rehabilitative nursing services.

160.1 Principle. A nursing facility which has a recognized TBI unit will be reimbursed for services provided to recipients covered under the Title XIX Program based upon the actual cost of services provided. The Department will establish the rate and determine that the cost is reasonable and adequate to be an efficiently and economically operated facility in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards.

160.2 Cost. The Department's payments made for allowable TBI services provided will be based on the actual cost of services provided to The allowable per diem cost for TBI services will include a routine service component and a rehabilitative ancillary service component.

160.2.1 The direct, indirect and routine cost component rates, that is, (The direct, indirect and routine costs less fixed costs and ancillary service costs) will be increased annually by the rate of inflation, for cash flow purposes only, at the beginning of a facilities fiscal year. This per diem rate is subject to audit and will be adjusted to actual costs at year end.

160.2.2 Rehabilitative ancillary services included in the care of a traumatically brain injured individual residing in a recognized TBI unit shall be considered an allowable cost. Covered ancillary services must meet the requirements and definitions under Medicare regulations.

160.3 Rehabilitative ancillary services are not subject to the routine service cost limitations.

Rehabilitative ancillary services include:

- Physical Therapy Services
- Occupational Therapy Services
- Speech Pathology Services
- Respiratory Therapy Services
- Recreational Therapy Services
- Physiatry Evaluation and Consultation Services
- Neuropsychology Evaluation and Consultation Services
- Psychology Evaluation and Consultation Services

160.4 Cost Reporting. Costs will be reported on forms provided by the Department which will segregate NF-TBI routine costs and TBI ancillary costs from standard NF costs.

For the purpose of calculating a separate NF-TBI rate, whether interim or final, a facility that has been granted a special NF-TBI rate for a distinct part shall allocate its costs to the distinct part as if the distinct part were licensed as a separate level of care.

All other principles pertaining to that allowability, recording and reporting of costs shall apply.

171 COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS

COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS PROVIDING SERVICES UNDER CONTRACT WITH THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (DMHMRSAS) TO FORMER PATIENTS OF THE AUGUSTA MENTAL HEALTH INSTITUTE (AMHI) AND THE BANGOR MENTAL HEALTH INSTITUTE (BMHI).

The Department may designate specialty nursing facility units that provide special services under contract with the Department of Mental Health and Mental Retardation and Substance Abuse Services to former residents of the Augusta Mental Health Institute (AMHI) and the Bangor Mental Health Institute. It has been determined that the reasonable cost of services for these residents, who have multiple medical needs that make them eligible for nursing facility level of care and have a primary diagnosis of mental illness that requires the ongoing supervision of trained professionals, is an allowable cost. This requires the nursing facility unit to possess characteristics, both in terms of staffing and physical design, for providing services to these patients.

Such designated specialty units shall be subject to the provision of these rules, except for the rate limitations contained in Sections 80-87.

The Department will require that the facility obtain prior approval of its staffing pattern for the nursing and clinical staff associated with these facilities from the Bureau of Medical Services. In the event a facility believes that the needs of the residents it serves have increased or decreased, the facility must request prior approval from the Bureau of Medial Services authorizing such a change to its staffing pattern.

171.1 Principle. A nursing facility which is recognized as a specialty unit under this section will be reimbursed for services provided to residents covered under the Title XIX program based upon the actual cost of services provided. The Department will establish the rate and determine that the cost is reasonable and adequate to be an efficiently and economically operated facility in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

171.2 Cost. The Department's payments made for allowable services provided will be based on the actual allowable cost of services provided to such residents. The allowable per diem cost for the services will be increased annually by the rate of inflation at the beginning of each facility's fiscal year. This per diem rate is subject to audit and will be adjusted to the actual allowable costs of providing services to such residents in these units at year end.

171.3 Cost Reporting. Costs will be reported in a manner that will segregate the costs of such residents in the specialty unit from the costs of other residents in the unit and the standard nursing facility's costs as apply under these Principles.

For the purpose of calculating the reimbursement rate for such residents in the specialty unit, whether interim or final, a facility that has been designated as a specialty unit under this section of the Principles for a distinct part shall allocate the costs of such residents in the distinct part as if the distinct part were licensed as a separate level of care.

All other sections of theses Principles pertaining to the allowability, recording, and reporting of costs shall apply.

APPENDIX A: DEFINITIONS

The term Department as used throughout these principles is the State of Maine Department of Human Services.

The term State Licensing and Federal Certification as used throughout these principles are the "Regulations Governing the Licensing and Functioning of Nursing Facilities" and the Federal Certification requirements for nursing care facilities that are in effect at the time the cost is incurred.

Accrual method of accounting means that revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

AICPA: American Institute of Certified Public Accountants

Allowable costs are those costs which Medicaid will reimburse under these Principles of Reimbursement.

Ancillary Services: medical items or services identifiable to a specific resident furnished at the direction of a physician and for which charges are customarily made in addition to the per diem charge.

Base Year: A fiscal period for which the allowable costs are the basis for the case mix prospective rate.

Capital Asset: Capital Asset is defined as services, equipment, supplies or purchases which have a value of $500 or greater.

Case Mix Weight: A relative evaluation of the nursing resources used in the care of a given class of residents.

Cash method of accounting means the revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

Common Ownership: Common ownership exists when an individual possesses significant ownership or equity in the provider and the institution or organization serving the provider.

Community Integrated Rehabilitation: Individuals in this category may be able to achieve sufficient function to live adaptively and manage his/her environment in a community-based setting of choice and is expected to tolerate 3 - 5 hours of rehabilitative services within the first 20 days of residence. The individual needs intensive rehabilitative services from one or more of the following disciplines: PT, OT, SPT, RT, Social Work, and Psychological Services. The individual has potential for a discharge destination which is a more community integrated setting.

Compensation: Compensation means total benefit provided for the administration and policy-planning services rendered to the provider. It includes:

(a) Fees, salaries, wages, payroll taxes, fringe benefits, contributions to deferred compensation plan, and other increments paid to or for the benefit of, those providing the administration and policy-planning services.
(b) The cost of services provided by the provider to, or for the benefit of, those providing the administration and policy-planning services, including, but not limited to food, lodging, and the use of the provider's vehicles.

Comprehensive Rehabilitation (Progressive Rehabilitation/Transitional Rehabilitation): Individuals in this category are able to achieve stability of function in physical health and self care to move to a more community integrated setting and is expected to tolerate 3 hours of rehabilitative services within the first 20 days of residence. The individual needs intensive rehabilitative services from one or more of the following disciplines: PT, OT, SPT, Social Work, and Psychological Services and/or Recreational Therapy. The individual has potential for a discharge destination which is a more community integrated setting.

Control: Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

Cost finding: the processes of segregating costs by cost centers and allocating indirect cost to determine the cost of services provided.

Days of Care means total number of days of care provided whether or not payment is received and the number of any other days for which payment is made. (Note: Bed held days and discharge days are included only if payment is received for these days.)

Direct Costs: costs which are directly identifiable with a specific activity, service or product of the program.

Discrete Costing: The specific costing methodology that calculates the costs associated with new additions/renovations of nursing facilities. None of the historical basis of costs from the original building are allocated to the addition/renovation.

Donated Asset: an asset acquired without making any payment in the form of cash, property or services.

DRI: Data Resources Institute Incorporated national forecasts of hospital, nursing home, and home health agency market baskets as published by McGraw- Hill.

Experience Modifier: This is the rating number given to nursing facilities based on worker's compensation claims submitted for the previous three years. The lower the rating number, the better the worker's compensation claims ratio.

Fair Market Value: The fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the